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the CHILD

"ROOMING-IN" GIVES BABY A GOOD START

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MORE AND MORE frequently joint conferences of various professional disciplines concerned with health are getting together to discuss their common problems and to work out ways of cooperating to promote the patient's health and satisfaction. These meetings show a need to discover ways of restoring something that was lost, or at least obscured, as the general practitioner gave way to the specialist. That something is the physician's professional attention to the personality of the patient.

Psychiatry, the youngest specialty of the medical profession, has picked up this neglected link—largely through psychoanalytic orientation. And with the help of psychosomatic medicine, the personal side of medicine is finding its scientific place among the various specialties.

Psychology and hospital care

What then, may I ask, are some of the psychological generalizations that are pertinent to the subject of optimal hospital care of newborn babies and their mothers? (I ask the reader's patience if for the moment the following items seem far afield.)

1. There is an alarming proportion of psychological illness in people of all ages. Physicians in private practice and those at out-patient clinics say that 50 percent or more of their patients suffer from some sort of emotional troubles. The number of men rejected as unsuitable for military service for psychopathological reasons lends forceful statistical support to such clinical impressions.

2. The emotional disturbances (personality disorders, neuroses, and psychoses) are as a rule rooted in early childhood; they develop according to the interplay of a fixed hereditary factor with the variable factors: (a) Stage of development, (b) environment, and (c) experience.

3. Emotional as well as physical development is individual, but ordered, with certain needs of the child predominating at various times. Satisfactory experience at each stage predisposes to the happy and successful adjustment at successive phases. Lack of satisfying experience, or injury, during any early phase interferes with the successful mastery of succeeding phases, and this leads to distortion or imbalance of reactions.

4. Injury to the developing personality may be caused by anxiety and guilt from within, and by pressure and denials from without, of a severity too great for a tender young organism to withstand. These may be listed as the child's fear of loneliness, his fear of loss of parental love, and his fear of punishment; and, also, parental expectations that the child live up to standards of behavior too advanced for his immature capacities.

5. The first needs of the child, according to present tenets, are: (a) Prompt satisfaction of hunger and of the urge to nuzzle and suck, (b) a feeling of warmth and support from the nurturing mother, and (c) peaceful, undisturbed rest between times.

Accordingly, the first injury that can be inflicted on the personality of the helpless infant is to refuse food and comfort when he needs it, or to force food upon him when he is not ready for it or already has had enough.

Repetition of such traumatic situations brings adverse reactions in both child and parent, and leads to later difficulties in the guiding and training of the child.

6. Children, however they may have been affected by the stresses of growth and environment, do in time become adults. And their adult reaction to people, to their work, and to their marital life and parenthood varies according to the way they have weathered, or succumbed to, the conflicts and hurts of growing up.

Hospital sets pattern

Hospital treatment of mothers and newborn infants has for various practical reasons tended to neglect variables. With routine separation of the infant from his mother, the above-mentioned infantile needs of the infant and the fundamental urges of normal, mature mothers to love, fondle, nourish, and watch their babies have been disregarded.

The hospitalization period, though short, has a far-reaching effect because mothers in general tend to follow the pattern of infant management set up in the hospital. They regard it as authoritative and more to be obeyed than their instinctive feelings (which may, indeed, have been squelched and belittled in childhood), more to be taken account of than the child's unhappy resistance.

There is thus a separate conflict for the parent and for the child in this opposition of authority to feelings, whose interaction stimulates a vicious circle of distress between them. If this is not broken by some concessions to the natural needs of each, there is breakdown somewhere.

At this point the pediatric-psychiatrist comes in as the mentor for parents who are at their wits' end with unmanageable children. His job is to trace the difficulties to their source in an attempt to restore balance, happiness, and health.

Through the mother's story, his attention is inevitably drawn to her uncertainties and perplexities since the time the child was born, to her lack of

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From paper read at the Third American Congress on Obstetrics and Gynecology in St. Louis, Mo., September 8, 1947, before a joint meeting of the hospital-administration, nursing, and public-health sections, on better maternal and newborn care. The panel included a contribution from an obstetrician, from a nurse, and from a pediatric-psychiatrist.

A mother cares for her baby at the George Washington University Hospital, Washington, D. C.

knowledge of what a baby really is like and what his characteristic changes are during development.

Inevitably he reaches the conclusion that the routine separation of infant from mother in the hospital, each being cared for as a separate assignment by separate nurses and separate doctors, is far from ideal; that it works deprivations for both mother and child; and that it certainly does not contribute to the mother's understanding of her child or to her new relationship in the family.

Why separate mother and baby?

Quite naturally the question has been raised: Why can't normal mothers who are looking forward to the care of their babies have them within sight and reach in the hospital (as well as at home) and learn by watching them, and under supervision, the first principles of infant care? Why not, indeed, if it is better for both mothers and babies? What can now be the justification for separating a mother from her healthy newborn infant? Why not have them in a room together? Dr. Arnold Gesell and Dr. Frances L. Ilg, working from the child-development point of view, came to the conclusion that mother and baby should be together, and in their book, "Infant and Child in the Culture of Today" (1943), suggested what they called a "rooming-in arrangement."

In following out this line of thought, different types of rooming-in projects are being worked out: For the maternity wing of the new George Washington University Hospital in Washington, D. C. [*1*]; in four Detroit hospitals, in single-room arrangements, through the mediation of the Cornelian Corner of Detroit, an organization composed of members of the medical and other professions concerned with social welfare [*2*]; and at the Grace-New Haven Community Hospital, in a four-bed rooming-in unit at the end of the maternity ward [*3* and *4*]. Dr. Henry L. Barnett has recently reported general observations from his 2 years' experience in the 12-bed maternity ward of the hospital at the atomic-bomb project at Los Alamos, N. Mex. Without discussing the reasons for undertaking this arrangement, he states that "the reactions of both the parents and the professional personnel to the arrangement as described were almost unanimously favorable" [*5*].

The rooming-in unit in New Haven has been in continuous operation since October 29, 1946, accommodating during its first 10 months 162 mothers with their babies.

The generally enthusiastic response of the parents to rooming-in is uncontrovertible evidence of some essential satisfaction it has afforded them. I believe this satisfaction will reflect essential benefits upon the children as they develop.

The nurses and doctors have also had great satisfaction in this unified service, which has in turn increased their ability to give sympathetic care to both mothers and infants.

Development of the plan in New Haven grew out of understanding cooperation between the department of pediatrics, the department of obstetrics, the school of nursing, and the hospital administration. A contribution from a commercial firm made possible the appointment of a full-time pediatric fellow and a full-time nursing fellow for conducting the work of the unit under the supervision of a committee whose members represent the cooperating departments.

The idea of a flexible modification of maternity and newborn care has met a ready response from mothers on various economic and professional levels, who have suffered some adverse reactions to their previous lying-in experiences, such as frustration, even bitterness (when they wanted to nurse the baby and were not helped to do it), and a general feeling of helplessness and ignorance on going home with the baby.

For fuller experience

Thus the procedures of the rooming-in project are based on the doctor's wish that the baby should have a fuller experience with the mother and the mother's wish to have fuller experience with the baby.

The procedures may be described as follows:

Every mother that is accepted for rooming-in is selected in the prenatal clinic on the basis of her wish to nurse her baby and her wish to keep him beside her after he is born.

Each mother selected is interviewed several times during the latter part of her pregnancy by a "rooming-in" pediatrician after her regular appointment

with the obstetrician. The pediatrician tells the mother about the unit policies and encourages her questions, so as to relieve unnecessary anxiety and to direct her attention toward immediate plans for the infant.

The mother thus becomes acquainted with both the obstetrician and the pediatrician who will be in charge of her and her baby when she enters the unit.

Her husband is encouraged to be with her during the first stage of labor and to accompany her and the baby after delivery to the unit for a brief bedside visit. He may hold his baby, after putting on a hospital gown and washing his hands, at each of his daily visits during the 8-day hospital stay. He may learn to change the baby's diapers or to adjust him to the mother's breast if the baby demands a feeding while he is present.

There is always a nurse at hand, and the mother is free to request care for herself or her baby when she needs it or to take care of her baby herself when she feels ready. The baby may be moved to or from a cubicle nursery at the end of the room at any time, according to the mother's wish.

Only two people in addition to the husband may visit the mother during the hospital period, and only one person at a time. The baby is on the "ad lib" schedule and the mother also, to the extent that she need not be roused for the usual hospital routines. The unit is attractive, homelike, and quiet in atmosphere. The quiet is due not only to a sound-proof ceiling but to the general contentedness of the babies.

For emotional continuity

In selection of mothers for the rooming-in unit, priority has been given to those who want to nurse their babies. The unit policy of flexible schedules is particularly suitable to the mutual needs of the "nursing couple" (though the few non-nursing mothers that have been accepted have been equally appreciative of the arrangement). The emotional continuity or relationship between a mother's wish to breast feed her baby as a natural process, to keep him naturally close to her, and to have a natural childbirth has been noted by physicians and parents alike.

Of the first 100 mothers admitted to the rooming-in unit, 15, on their own initiative, which was stimulated by their reading, [6] requested the help of the obstetrician toward a natural, conscious, childbirth experience. Nine of these were successful with no anesthetic at all. From the pediatric-psychiatric point of view the importance of a mother's wish for conscious participation in the reproductive process cannot be overlooked. Mothers who choose to face the full experience of life without obliteration or denial are not likely to cheat their children of the truth. An honest environment without misrepresentation or false assurance is a most salutary influence for the growing child.

A 38-year-old mother expressed her appreciation of the supportive interview with the pediatrician at the prenatal clinic. This mother had had five miscarriages for no apparent reason, and had carried no previous pregnancy to term. She succeeded in carrying her sixth pregnancy to term and was admitted to the rooming-in unit. In a bedside conversation on the second day after the baby was born she spontaneously expressed her appreciation for the helpful interest of the rooming-in staff and told how much it had meant to her and her husband.

She recounted that she had been kept in bed for the first few months of this pregnancy, by a private physician, and that she finally came unwillingly to the prenatal clinic. She had felt distinctly mistrustful, because of her past experience with hospital clinics.

She hadn't dared to think of the baby as a real possibility. Only after the first interview with the doctor at the prenatal clinic in relation to rooming-in did she feel reassured, and for the first time, although she was in the eighth month of pregnancy, she and her husband began to talk about the baby, to admit his existence as a fact. She felt then that she had her own doctor and that the baby had his own doctor, too. We cannot concretely evaluate the meaning of sympathetic rapport between a prospective mother and her professional advisers. We may be content to say that it is immeasurable.

Play by play

One of the first private-status mothers to make application for rooming-in was an attractive, serious, and intelligent young mother of two children. She definitely wanted a different type of experience with this third baby—different from the experiences that she had had with the other two. Her reading and her associations had led her to believe in the value of natural childbirth, of breast feeding, of flexible feeding schedules for the infant.

Her labor was relatively short and entirely conscious. She described the delivery as follows in a bedside interview 3 days after the baby was born:

"It was very pleasant in the labor room—my husband and I talked. I didn't have any desire to shoo anyone away until just before I was taken to the delivery room, when the contractions came strong and close without distinction between.

"In the delivery room I kept waiting for the big one. I was relieved that I could ask questions and get answers. I never knew before what was going on. I was very surprised to find out about the blissful feeling of rest and relaxation between the bearing-down pains.

"In retrospect I am surprised that I was as alert as I was; I thought I would go vegetable, but I remember everything clearly. I couldn't believe it when the head appeared!"

According to an eyewitness account, when the delivery was complete she meditated aloud, "Well, I'm flabbergasted! If babies weren't so expensive, we could have one every year!"

The impressions of the husbands who share the wives' ideals of responding naturally as far as possible are also noteworthy. The next page presents the comments written by the husband of a mother who had experienced a successful natural delivery of their first baby.

The mother herself had written a play-by-play account of her labor for the obstetric-nursing supervisor, which began, "Isn't having a baby wonderful? Not just having him after he is born, but the whole process of his entry into the world," and ended, "If all women could go through labor with my experiences, I am sure they would agree that having a baby is wonderful." They both regretted that their husbands could not witness the birth of the child.

The husband wrote, "The thrill my

wife experienced from her labor had its counterpart with me. I say honestly that while I had secretly worried previously about her labor as I suppose all husbands do, I became so interested in it at the hospital that worry changed to the excitement of wonder and expectancy. Fortunately my studies [he is an educator] had led me to a fairly good idea of what to expect, and it was with great pleasure that each expectancy became real in its turn. My wife believes she enjoyed her labor because she knew what was happening. Estimating by conversation with other fathers in the ward, I should say that I, too, profited by being in on the mysteries of the process.

"Exactly how important it is that the birth was a pleasure to me I do not know. Conversely, however, I can imagine that the effect of a really unpleasant experience might be the seed of several later difficulties. . . .

"Events preceding labor were just as important to my wife as those that took place at the hospital. The preparation she had at the clinic was excellent. She started pregnancy with a thousand fears (which I shared). Gradually she reported these as eliminated. . . .

"Though this is not really connected with the delivery, I should like to say that rooming-in draws nothing but praise from me, and my wife believes the same. It is impossible for me to see how any other plan for maternity care in a hospital could ever have been permitted, let alone desired."

Enriched maternity care

In conclusion, I quote a letter from a relatively recent roomer-in—an entirely spontaneous communication. Since it summarizes the enrichment for maternity care which has been the goal of rooming-in procedures, there is little more to be added. The almost missionary fervor of the letter is characteristic of many of the mothers who have elected rooming-in. This must have a meaning. We shall have to ponder well its implications.

"Dear Doctor J: I have been trying to get a chance to drop you a note. I want you to know how much I loved your rooming-in project. Our baby is now 7 weeks old and doing wonderfully. I am still nursing her and have more and more milk for her.

"All the above, I am sure, is so wonderful because I was one of the few fortunate ones to try the project. It was wonderful. When we came home from the hospital we had no period of getting acquainted. Even though this baby is our first, I know the problems the girls who live near me have had. To quote one girl, she 'didn't know the baby cried. He never cried when he was brought in and out again.' Just two or three cases like that are just within calling distance, and I know how very fortunate I was.

"Several people have asked how I got any rest with the babies crying. They just don't understand that I learned to hear only my own baby and that when she cried I had all kinds of professional advice within earshot. That is a very satisfying feeling for a new mother.

Husband learns to hold baby

"I should mention my husband's feeling about the project. The night the baby was born he had the opportunity to hold her and then at every visit he held her. Besides being thrilled he learned how to hold her and was plenty of help when we came home. He held her as if he had been doing it all his life.

"I could go on page after page telling you how wonderful it is. I won't, but before I close I would like to mention the staff. It was also very wonderful to have a visit from you and Dr. O. every day. Any questions I had were answered soon after I thought of them, and sometimes they may have been very silly questions but they were all treated as though they were equally serious, and I had an answer given for each one I thought up. Since I have been home I have had three visits from the doctor, just to see how I am doing. So even anything that developed at home was soon cleared away.

"The nurses were certainly wonderful. Each one was full of life and fun, but when called upon for help were more than willing and did many extras for all of us. I never saw nurses who were so busy all the time and yet always willing to do another little thing to make one comfortable.

"The meals were wonderful. I was talking about dieting (just in fun) but every time the tray came in I had to admit the food won. We had little snacks between meals and it was just like being at home, raiding the refrigerator.

"Well, Doctor, I really must close, but I just want you to know how much I appreciate being chosen to try out the new project and I hope I can have it for each of my succeeding babies.

"Good luck, and I hope some day you will be able to enlarge your space and so accommodate everyone."

Mothers like rooming-in

It is clear that the response of the mothers to their experience in the rooming-in unit has been very favorable. The unified nursing care under joint obstetric and pediatric supervision is one of the important factors for the success of the undertaking. In its broader aspects the effort to supervise consistently both mother and child during pregnancy, during the lying-in period, and postnatally through visits to the homes, has helped to win the mothers' strong allegiance to the rooming-in project and their wish to encourage the expansion of rooming-in facilities. In fact, many mothers have shown a remarkable missionary zeal in this respect. It is my impression that rooming-in facilities should be available for all mothers who want it, but should not be pressed on mothers who feel opposed to the idea.

References

1. McLendon, P. A., and Parks, J.: Nurseries Designed for Modern Maternity. Modern Hospital, 65: 46–49. July 1945.

2. Moloney, J. C., Montgomery, J. C., Trainham, G.: The Newborn, His Family, and the Modern Hospital. Modern Hospital, 67 : 43–46. December 1946.

3. Jackson, E. B. and Thoms, H.: The Rooming-in Plan for Mothers and Newborn Infants. Connecticut State Medical Journal, 11 : 175–176. March 1947.

4. Jackson, E. B.: Mothers and Babies Together. Parents' Magazine, 22 : 18–19, 146.

5. Barnett, H. L.: A Note on Experiences With a Rooming-in Arrangement for Newborn Infants in a Small Hospital. Journal of Pediatrics, 31: 49–53. July 1947.

6. Read, Grantly Dick: Childbirth Without Fear. Harper & Bros., New York. 1944. 259 pp.

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WHAT SHALL I DO WITH MY BABY?

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WE, as social workers, have long felt that one of the most complex problems facing us is the task of helping the unmarried mother reach a decision about plans for the future care of her child.

Our close contact with the unmarried mother makes us quickly aware of the conflicts and anxiety that she feels when faced with the necessity of making a decision about her child; and her vital emotional stake in the problem is clearly evident to us.

At the same time, the worker is equally aware of what society as a whole feels about the problem, and the stake that society has in the future planning and well-being of the child, as well as society's concern with the problem of the unmarried mother herself, a concern which has been sometimes punitive and other times reformist.

Frequently, because of our understanding of the emotional disturbance of the unmarried mother, and our anger against the harshness of society's judgment, we have set out to combat these judgments by aligning ourselves with the client and sometimes even propelling her into a plan that ignored the basic factors in the situation.

In this way we sometimes impeded the ultimate adjustment of the mother and the child into society, despite the fact that we were so anxious to have society accept them.

Still later in the development of our professional skills, we became aware of a third stake in the problem—the stake of the case worker herself. We realized that our experiences and feelings toward our own parental relationships frequently colored our attitudes toward the mother and her child, and in many cases played a significant role in shaping the client's decision.

This growing awareness brought with it additional hazards in our work with unmarried mothers. In an effort to make certain that the mother was free to make her own decision uninfluenced by the attitude of the case workers, the worker also frequently failed to participate in this vital decision. And failing to give her client the necessary support, the worker left her to face the entire burden of the decision alone.

Our developing perspective on the problem has been shown in the historical pattern of dealing with the unmarried mother and her child. For many decades the foundlings' home was the major solution offered by society to rid the mother of the evidence of her guilt and at the same time to offer the child a chance of survival. But this was a harsh solution, wherein no heed was given to the needs of the mother, and the existence of the child in both physical and emotional aspects was grim.

Later, with the emergence of case work as a planned procedure, emphasis was placed on the desirability of the unmarried mother's keeping her child with her. This was in part due to the social worker's earnest desire to modify the harsh attitude of society, and in greater part due to the growing understanding of the importance of family life in the emotional development of the child.

Mothers who were undecided about plans for their babies were urged and encouraged to keep their babies with them.

Maternity-home procedures were planned so as to encourage formation of an emotional bond between mother and baby, and from this developed such requirements as compulsory breast feeding by the mother, an insistence that all mothers give personal care to their babies, and requirements that the mother and child live together in the maternity home for a stipulated period of time after delivery.

In our zeal to secure the advantages of a mother's love for the child, we tended to assume that the mere act of living together necessarily would give the child the security and affection that goes with satisfactory family living.

Given at the Minnesota State Conference of Social Work, Minneapolis, May 5, 1947.

Many people today, both in social work and in the outside community, feel that the unmarried mother should be encouraged to keep her child, just as there are many people who believe that the only adequate solution for the future of the child of the unmarried mother is placement away from the mother in an adoptive home.

For a long time, however, most of us have been aware that neither of these answers can be applied in all situations. We have striven for our answers on a case-by-case basis, knowing that it was only through understanding the dynamics of each situation that we could determine the meaning that *this* child had for *this* mother, and thereby help her make a plan that would best meet her own needs as well as the child's needs.

We in Chicago have been giving a good deal of thought to the problem of helping the unmarried mother in her decision about the baby. An institute was recently held here under the auspices of the Council of Social Agencies, dealing with the problems that we are talking about today.

Do we emphasize mother or child?

In our planning for this institute, the members of the committee sat down together to discuss and clarify their own thinking about the relationship between the unmarried mother and her child, and to see what reconciliation would be needed between divergent points of view.

Since service to the unmarried mother is given by various types of agencies, we found that our thinking about the problem was frequently affected by the function of our own agency.

The major point of discussion seemed to be whether our primary emphasis lay with the interest of the mother or the child. Which of the two was the major responsibility of the agency? And upon which was the primary emphasis of our work to be placed?

As we talked further, the points of difference seemed to lessen and we emerged with the definite feeling that not only was there no single plan of action that was preferable in all situations, but also, except for rare instances, there was no basic conflict between the best interests of child and mother.

We realized also that our best possibility for working out a sound plan for the future welfare of the child lay in helping the mother to work out her own problems, since it was only in this way that she could be free to make a sound plan for her child.

We have long recognized the complexity of emotions and behavior, and we know that for this reason the decision regarding the child could not be an isolated factor in the life of the unmarried mother.

We know that this decision would be influenced by the same emotional factors that had entered into the pregnancy and the total behavior pattern of the unmarried mother, and that it was through an understanding of these factors that we and she could best ascertain the meaning of the child to her.

We have seen this in many situations where a thorough exploration of the present situation has clearly indicated the inadvisability and even the impossibility of the mother's keeping her baby.

The mother herself has participated and is in agreement with this conclusion. Nevertheless, she finds herself completely unable to carry out the decision that she herself expresses as being best for herself and for her child. We know then, that reality for this girl contains other elements than those in her present life situation.

This does not in any way imply that external realities should not be given full consideration, or that they should not be presented by the worker and carefully explored with the mother. On the contrary, it is vitally important that this be done, since the girl herself may be so strongly motivated by inner psychological pressures that external realities have little meaning for her.

It then becomes the function of the case worker to help the girl understand the psychological pressures and to relate them to the realities of the present situation. We know that no plan can offer happiness for the mother or the child if the plan ignores the present reality, but it is important to expand our concept of reality so that it includes the psychological realities of the girl's situation as well as the external realities.

Let us briefly consider some of the plans that these girls bring to us.

Many of the girls who come to us state with fixed determination that they plan to keep their babies. Some of them have the backing of their families in this decision, and the circumstances of their lives indicate that despite many hazards the baby may have some degree of security in living with its mother.

Many more, however, have little mature warmth or security to offer the child, and the plan seems to offer serious disadvantages both to the girl and her baby. What, then, impels these girls to cling to their babies?

Dr. Margaret Gerard of the Institute for Psychoanalysis in Chicago recently pointed out that many of the unmarried mothers coming to us for help are impulsive and infantile individuals, whose own dependency needs may lead them to hold tenaciously to their babies. Sometimes this is because the girl feels that her family, or perhaps the worker, expects it of her. Or she may cling to the child through inability to relinquish any possession for fear that she may regret its loss at some time in the future. One factor that Dr. Gerard pointed out is of particular importance for us who must help the mother in making a decision.

Repeated experience has shown that the more dependent, immature women whom we know to be inadequate mothers practically always choose to keep their babies once they have seen and handled them. This choice grows, not out of an ability to care for the child, but out of the wish for pleasure for herself. We have all known mothers who, long after taking the baby, have found the difficulties which faced her overwhelming, and have come to us, saying, "If I only hadn't seen my baby I could have given him up." They have blamed the worker for not having helped them to make a plan that would have made this possible.

Medical social service helps

In Chicago we have been able to secure the cooperation of many of the hospitals in carrying out such plans, particularly those hospitals that have medical social-service departments. In these hospitals the mother does not have to see her child if she does not wish to, and in that case the baby is placed on a formula immediately after birth. This, of course, is done only with the mother's approval, and the baby is brought to her if at any time she changes her mind. In this way the girl has the support of her worker and the hospital in carrying through the plan that she basically desires, but which she might not be able to carry through if her feeling of guilt were increased by enforced personal contact with her baby.

Many other unmarried mothers need to cling to the child because of their attachment to his father, and the hope that through the baby they can still maintain a tie with him. Others who have been led into pregnancy as a result of their own disturbed family relationships, need to keep their babies as a help in working out these relationships. Some need to reinforce their dependence upon their families; others, to bring about their emancipation from an overly dominating family. The latter problem is illustrated as follows:

Dorothy J. was referred to our agency by a worker in the social-service department of the court, who felt that she needed help because she was greatly distressed over the pending adoption of her baby. This adoption had been privately arranged by Dorothy's physician, and she had already signed relinquishment papers before the clerk of the court. However, in the process of the adoption study which was being made for the court, Dorothy was interviewed and was most emphatic at that time in saying that she wanted to keep her baby and that she had signed the adoptive consent only because of coercion from her mother and the doctor.

She was under a great deal of tension when seen by our social worker and spoke with considerable excitement. She told of the pressure that had been put upon her by the doctor and her mother to consent to the baby's adoption, and of their threats to take her to court to prove her an unfit mother if she persisted in keeping the baby. She said that the doctor had even had telephone service cut off from her hospital room and had told her that she would not be able to go home with the baby unless she had money to pay the hospital bill and the bill for his services.

However, although she repeated her anxiety to keep the baby she could offer no tangible plan for his care. Dorothy was still living at home with her mother, and felt that it would be impossible for her ever to leave home. She was earn-

ing an adequate salary as a secretary, and felt that she could support the baby, but that it would be impossible for her to take him home because of her mother's opposition. There was some fantasy of a later marriage to the baby's father, but when this was discussed Dorothy herself expressed considerable distaste for such a marriage, feeling that the man was considerably beneath her, socially and educationally.

Since it seemed probable that Dorothy's consent had been obtained through duress, she was assured that legal assistance would be given through our legal-aid department. At the same time arrangements were made for her to have regular interviews with the social worker to help in making future plans. The worker felt that there was great conflict in Dorothy's mind about plans for the baby, despite her verbalized insistence on keeping him, and she felt that Dorothy's inability to consider tangible plans, as well as her need to remain in her parents' home, might indicate that she did not actually want to keep her child. What then was the meaning of this child to Dorothy, and why did she need to cling so desperately to him?

As the interviews progressed Dorothy was able to bring out a great deal of her feeling toward her family. As an only child she had been the absorbing interest of her dominating mother, a mother who at the same time had not given her a great deal of warmth. Her father was a pleasant but passive person who had played an unimportant role in the family, the same kind of role that the baby's father played in Dorothy's mind.

Mother has conflicting desires

The root of the conflict became more clear. She had a desire to emancipate herself from her mother's control and become independent, coupled with a desire to remain dependent upon the family and win her mother's affection in that way. This conflict had led to the relationship that resulted in her pregnancy, and also to her desire to keep the baby, against her mother's wishes.

As the interviews progressed, Dorothy herself became more aware of the confusion in her feelings toward her family, and her need to hold on to her child seemed to be decreasing. One day she spontaneously sent a letter to the legal-aid bureau attorney stating that she wanted to drop the action for the custody of the baby since she felt that the child would have no real security with her and would undoubtedly be better off with the adoptive parents.

She is still continuing her interviews with the worker, and although her relationships at home are not happy, she has shown a capacity for greater activity and increased friendships outside the home. This of course came about not only through her understanding of her own feelings, but also because the worker in many ways served as a mother substitute for Dorothy, a mother who was less restrictive and without need to control.

This may seem a strange case to present as an illustration of problems concerning keeping the baby, since it starts and ends with an adoptive situation. However, it is illustrative of the kind of motive that frequently impels a girl to keep her baby when she does not actually want him.

Adoption brings child some security

The next large group we meet is made up of girls who plan to have their babies adopted. Social workers always feel some security in dealing with this group since they know that if a placement is made through an authorized agency the baby at least will have some security for the future.

Sometimes, however, because of our reassurance about the baby we tend to neglect the emotional needs of this group of mothers. This is understandable in many ways since the pressure of work frequently forces us to use our time and effort on situations where the mother is undecided about plans and the future of the baby is in jeopardy. However, we are frequently surprised when all the plans are made, and the mother then changes her mind or is thrown into a panic of indecision. Sometimes this happens because we have not been sufficiently sensitive to her conflict about adoption, and have not helped her deal with her feeling of guilt. Sometimes, even when this kind of mother goes ahead with the adoption plan, her feeling of guilt may lead her into another pregnancy.

The extent to which this can be carried is shown in the situation of Gloria, an attractive, quiet, intelligent girl of 22, who came to us one summer asking for maternity care. She said that she was married and separated, but that her husband was not the father of the expected child. She told us that she had one son by her marriage, who was living with relatives of her husband. She spoke to the worker in a frightened tone, and looked as though she expected punishment or criticism. The worker quickly sensed her need for reassurance, and discussed practical plans for her. Before Gloria left that day plans had already been worked out for hospitalization, financial assistance, and living arrangements.

Later, in checking on the records of other agencies, we discovered that this was really Gloria's fourth pregnancy, and that all four pregnancies had been illegitimate. The first two children had been placed in adoption by an agency, and the third had been placed privately. The worker felt that with this secret standing between them there was no possibility of helping Gloria; and she told the girl what she had learned, but reassured her of our continued interest. At this point Gloria dissolved into tears and could not discuss it any further. She was not pressed to talk, and we continued to plan to help her.

In the third interview Gloria began to talk about wanting to keep her baby. She showed great distress over giving up the first child. The other two children seemed more shadowy in her mind, but the giving up of the first child was still so vivid that it might have happened only yesterday. It was agreed that the important thing was to work out the plan that Gloria really wanted.

There had been no security in Gloria's early family life. Her parents separated when she was only 2, and she was shifted from one relative to another, spending several brief periods with her mother. Records indicated that Gloria had suffered real cruelty from her mother. On one occasion the mother had burned the little girl's hand for a slight misdeed, and relatives stated that the mother had really tried to starve her.

There was also evidence that the mother was promiscuous, but she was also very hostile to Gloria because the girl had been involved with men.

Gloria had had a better relationship with her father's family, who had a more respectable status.

It seemed apparent that Gloria's relationships with men were largely on the basis of reaching out for a family relationship. Most of the men involved were older, and she spoke frequently of the kindness and consideration they had shown her, although for various reasons they had been unable to marry her.

Gloria kept her baby and gave him excellent and devoted care. Because of our concern over the welfare of the baby, as well as Gloria's past history, we discussed the situation with our psychiatric consultant. It was felt that the situation was hopeful, and that the girl was now reaching out for help because she had been allowed to keep her child.

In her mind the agency was not associated with the punitive, depriving attitude of her own mother. We had shown her by our attitude that we did not condemn her, nor did we see her as a worthless person; and because of this she was now able to reach out for help in other areas.

Gloria has continued under care, and now that her baby is older, plans are being made with her for vocational counseling, with the possibility of day care for her child when she returns to work.

Child's happiness at stake

The group that concerns us most is composed of girls who ask for long-time foster-home placement for their babies. These girls neither want to keep the children nor are they willing to give them up, but hold on to them through the nebulous tie of keeping them in foster homes. We are all aware of the unhappy situation of such children, children who grow up in a foster home, knowing their own mothers. These children are prevented from forming close ties with the foster parents, but at the same time do not get the affection and security that they crave from their own mothers. Frequently the child feels divided allegiance, and a rivalry is created between his own mother and the foster mother. As this goes on, the child may be impelled to repeat the neurotic pattern of the mother which had been the cause of the original situation.

As for the mother, this kind of solution has frequently enabled her to put off facing any of her own problems, because she is able to escape into this indefinite plan for long-time placement of the baby. In the past many agencies frequently entered on such planning without thorough consideration of all the motives involved. This is now less likely because of the extreme shortage of foster homes. This shortage has now forced us to sharpen our skills so that the foster home can be used to the best advantage. It is true, of course, that long-time foster-home care is sometimes necessary, but this is usually a last resort.

If we accept the basic premise that the focal point of planning is to help the mother meet and solve her own problems, what implications does this have with regard to the agency program and the role of the case worker? There are a great many implications to be considered: The first is the need for flexibility in the agency set-up. This implies flexibility both in legislative provisions and in agency procedures.

It is important that assistance and service be available for nonresident unmarried mothers, since the very nature of their problem, and their ultimate rehabilitation into their own group, frequently makes it necessary that these mothers seek help in a locality where they are known to no one.

It is also important that various types of living arrangements be made available to the girls. In many localities maternity homes are the only resource, although we know that many of the more disturbed girls are unable to adjust in a group and because their emotional needs are not met in such a situation they are not responsive to casework help.

Rigorous requirements for paternity hearings should not be insisted upon, since it is frequently desirable for the girl and for the future welfare of the baby that all ties with the father be broken. Unless the future welfare of the child seems seriously jeopardized, it is important that the mother be given the right to determine whether or not she wishes to institute such hearings. This is particularly important of course in situations where adoption is considered, since a clean break with previous ties is clearly indicated here.

In considering the role of the social worker it is important that she be prepared to accept her own responsibility for helping the unmarried mother reach her decision about the disposition of the child.

Worker should not shirk duty

In our eagerness to permit our client the right to self-determination, we have frequently avoided our own responsibility in helping her to face one of the most vital problems that a girl can be called upon to meet. In many records we read such examples as the case worker who insists upon discussing alternate plans with the girl who has already resolved upon adoption for her baby, thereby confusing the girl and making her feel that the case worker, and therefore society, looks upon her as a bad mother for wishing to give up her child. We have all also read records where the mother specifically asks the case worker for advice and counsel, only to be turned aside by the worker who states, "It's all up to you."

We have all learned that one of the most important tools of case work comes through the relationship that is developed between the client and the worker. If we accept this premise, how then can we remain aloof and apart from so vital a decision? It is important to realize that any decision which the girl makes will have some painful aspects, and that it will be necessary to help her work through the feelings that may arise before and after her decision. It is also important that we fully convey to her the fact that even if she does not make the decision that we feel is best, we are still interested in her, and she can still turn to us for help.

The responsibility for making a decision for the future of an unborn child is indeed a grave one. We are all awed by the consciousness that here is an individual who as yet has been untouched by the problems of the world. What will his future be, we wonder? But as social workers, we have always had to carry grave responsibilities, and if the great amount of thinking that has recently gone into this problem is any indication, we will not hesitate to meet these responsibilities in their turn.

Reprints available in about 5 weeks

CHILD'S MENTAL HEALTH CAN BE FOSTERED

HENRY H. WORK, M. D., *Director of Mental Health Unit, Children's Bureau*

"WE have been educating for this war for 40 years," said a European physician to Dr. C. Anderson Aldrich during a wartime conversation. "The way we have cared for our babies and young children has encouraged the kind of personality that makes violent conflict inevitable."

Much of recent medical thought in this country is in agreement with this opinion. Physicians are realizing that a great deal of the advice that has been given to parents on the rearing of their children has led to damaged emotional health in both children and parents. Recent psychiatric investigations have taught us a bitter lesson about our methods of bringing up children.

How did these methods get started? And why is our progress in such fields as child nutrition in danger of being negated by our failures in applying our knowledge? What does it profit us to know what foods children should eat if they refuse to eat them? Perhaps study of recent errors can point to a solution of this problem.

At the turn of the century, scientific knowledge was growing rapidly. Doctors were beginning to learn what nutrition means in animal life. It was necessary, however, to study the effects of vitamins and minerals in the growing human as well as in the laboratory animal. Children, above all, stood to benefit by the application of this knowledge.

But in applying the knowledge, we adhered too rigidly to the methods that had been so valuable in establishing the importance of nutrition in growth. Into the discard went fulfillment of the emotional needs of the infant, or of the desires and abilities of the parents. The clock became the guiding beacon of infant care, and the measured ounce the talisman.

Now another generation of physicians is reaping a harvest of feeding problems that were planted by that rigidity.

For unfortunately admiration for the niceties of the laboratory schedule had spread to other factors in the relationship of parents and children and the method was applied to all aspects of this relationship.

A baby gets not only physical joy from his milk, but emotional satisfaction through sucking.

The child born in the hospital was taken from the mother soon after birth. If she was not actually discouraged from breast feeding, she did not receive much encouragement. Babies were weaned at earlier and earlier ages. And little children underwent early and sometimes vigorous toilet training.

These deviations from the familiar relations between the mother and her child produced changes in the child's growing personality and disturbance in his behavior.

It is hard on those of us who are concerned with the care and well-being of children to have the defects in our approach pointed out to us.

But we must admit, not only the increase in psychiatric problems relating to children's sleep, feeding, and bowel and urinary functions, but also the increase in frustrations that result in tense mothers and confused fathers.

What can be offered as an approach to a newer understanding of these problems? Shall we say that our recent knowledge leads us back to older methods? This recent knowledge derives not only from psychiatrists' studies of people of all ages, whose personalities have become warped, but also from a slowly growing but abundant fund of information on the growth and development of children. Let me emphasize that this field takes as much account of the changing emotional picture of the child as it does of his increase in height or weight. All these studies point in various ways to new feelings for the mother-child relationship, or perhaps a

restoration of them. They emphasize that no one factor of this relationship is of exclusive importance—that it is futile to consider the relationship from any single point of view.

Let us look at three broad aspects of this relationship.

The first concerns the growth of the child's abilities, and our part as parents in helping him to use them. Nobody expects a newborn to sit up or a 6-month-old to walk. But many of our practices in feeding babies and in teaching them to control the bowels and bladder repeatedly violate the principle that trying to teach a child before he is ready to learn is a worthless procedure at best. Our current knowledge suggests that it may be harmful as well.

Elizabeth can feed herself, but she is glad to have mother help with the last few spoonfuls.

Those who study the development of the body have shown us that the nerves develop slowly and that, until a connection has been established between a nerve and a muscle, the muscle will function badly or not at all. Once this nerve-muscle unit is complete, however, it is ready to learn its function in terms of the body as a whole.

A second aspect of change in the child is also involved with development; it is the change in the child's emotional outlook as he becomes daily more mature. The change is apparent as the child learns gradually to control the combination of fear and anger that he shows in early infancy whenever anything displeases him.

Again, our recent knowledge suggests that the baby's pleasure in getting his food includes more than physical joy in the milk; it includes emotional satisfaction in the act of sucking. When properly satisfied, this desire to suck diminishes; when this satisfaction is abruptly or forcibly denied, the urge may be turned into other channels. Although not every child who sucks his thumb has been subject to weaning difficulties, prolonged thumb sucking is frequently associated with such difficulties.

Thirdly, we must pay more attention to the change in the child's attitude toward the mother and in her appreciation of this. Everyone is aware of the total dependence of the newborn. Not so easily apparent are the subtle changes in the direction of the child's independence, which will some day culminate in his establishment of his own home, as an adult. Mothers vary greatly when it comes to relinquishing their desire for their child to depend on them. A few are never able to allow him to go free, and they blight his establishment of real adulthood. Or they give him too much independence, which may lead to his becoming devoid of any conception of the rights of others.

How, then, can we utilize our current knowledge in all these fields to foster stable personalities by giving a baby a good start in the earliest relations with his mother? One thing we can do is to encourage in every way the closeness between the mother and her child that was characteristic of earlier generations, applying to this relationship all we know of the child's growth, his development, and the changes in his emotional patterns.

An early step toward encouraging this beneficial closeness between mother and baby is described in this issue of *The Child* by Dr. Edith B. Jackson (pp. 162–165). Under an arrangement called "rooming-in," the hospital, instead of separating mother and newborn baby during the postnatal period as a routine measure, permits the mother to keep her baby near her. Such an arrangement gives the mother-child relationship an auspicious beginning.

We physicians can help this good relationship by not pushing either the child or the mother beyond their abilities, but instead recognizing that as the child grows his independence should increase. This will bring new responsibilities to the mother in satisfying his desire to learn and in encouraging his need for freedom. We must realize that a good relationship between mother and child must develop with his increasing needs rather than according to any standards that fit an experimental situation.

This attitude on the part of the physician, without urging an empty, or hostile, attention on the part of the mother toward the child, would foster a valid affection for him. Such affection should minimize friction, and subsequent frustration, and should breed respect on the part of the child.

If we can thus do something to eliminate the need for stern methods of discipline, we shall have made a beginning in educating people to live together in peace.

Reprints available in about 5 weeks

COUNCIL ASKS BETTER DEAL FOR MIGRANT WORKERS AND FAMILIES

"A SIZABLE SEGMENT of our population, through community and State neglect, has been robbed of so many normal American and human rights that it is almost unbelievable. Child labor, substandard living, and a padlock against education have destroyed the rights of children and drastically disturbed the integrity of family life among migrant workers."

These words, from the Report and Recommendations of the Federal Interagency Committee on Migrant Labor (1947), describe some of the conditions that the National Citizens Council for Migrant Labor has been formed to work against.

The council, which was formed in October 1947, is composed of individuals and of National, State, and local organizations. It expects to stimulate and assist in the establishment of regional, State, and local citizens' councils and to work with them toward improving the conditions under which migrants live and work. It recognizes the need for a comprehensive, long-term farm-labor program, which will include migrant workers.

Formulation of such a program, the council believes, should lessen the need for migrant labor through greater diversification, both in individual industries and on an area basis, and through greater use of local labor. The council calls on employers and public and private agencies and organizations to help in making this long-term program possible.

The council will be concerned with administrative policies of Federal, State, county, and local governments, with Federal and State legislation, and with the work of both public and private agencies insofar as they affect migrant workers and their families. Migrant labor, says the council, is cut off from most of the rights and privileges which other American workers enjoy. And the council will work for extension of all such rights and privileges to this group of workers and their families.

We present here parts of the council's program that concern children:

Recruitment and placement of migrant workers

The first need of migrant, as of other labor, is work. But the difficulties in finding work are much greater than are those of more settled workers. The migrant worker can, if he is not well informed as to where work is, waste a large part of his already irregular working season in wandering from place to place. Employers need migrant workers. It is essential that the employer, the migrant worker, and both Federal and State agencies work to use this shifting labor force to the fullest. This means that the worker must be told in advance where he can find work; he must be informed as to what the working and living conditions will be; how long the work will last; where he can go next in his migration. This is unquestionably the most difficult recruitment and placement problem in the United States.

* * * * *

The United States Employment Service needs sufficient funds to extend its regular services to all of the labor market areas and key points along the routes which migrant workers travel. Placement of migratory workers is not a job which can be handled from established offices alone. Greater effort should be made to transfer workers from agriculture to industry and back again as seasonal demands develop.

Child labor

It is quite customary for even very young children of migrant parents to work long hours in the fields. To prevent this, State child-labor laws must be extended to cover employment in agriculture. The child-labor provisions of the Fair Labor Standards Act should also be made to cover children in industrialized agriculture. In addition, State school-attendance laws must be extended and enforced.

Education

At present children of migrant families are denied the educational advantages which children of more settled parents enjoy. This is due not only to the nature of their parents' occupation, but often also to community attitudes which make these children unwelcome in the schools, and to the fact that many schools are not prepared to meet the special needs of migrant children. Both Federal and State aid, in money and in planning, are necessary if local communities are to give these children equal educational opportunities. The council will work for:

Admission of migrant children of school age to local schools.

Provision of extended school facilities, summer programs, parent education, specially devised units of study for migrant children.

Requirement of the same school attendance of children of migrant families as of the children of permanent residents. Provision of such State and Federal aid as will be needed to make available equal educational opportunities to children of migrant families.

Child care and youth program

Child-care centers for migrant children are needed. Nutrition, education, and feeding programs should be instituted. These services must be integrated with the basic health, welfare, and education programs of local communities.

Health

The council will sponsor a bill to provide medical, hospital, dental care, and drugs to migrant workers and their families, by Federal grants-in-aid to States. There are many rural counties in which migrant workers are employed which do not yet have preventive public-health services. Such services need to be extended to all of these counties.

* * * * *

Housing

The insanitary and dangerous housing often furnished migrant workers and their families constitutes one of the major problems of these workers. Beginning in the 1930's the Federal Government undertook the establishment of labor camps in the major crop areas. That program is now being liquidated and the camps are being sold. There is danger that they will be sold to associations of growers, and form part of a company housing program. The council endorses:

Sale of the federally owned camps to State or other public or semipublic

agencies, unless and until they are restored to Federal operation.

Reestablishment and extension of the Federal labor-camp program.

Enactment of State laws requiring licensing and regulation of private labor camps.

Inclusion of rural housing in public-housing programs.

Labor contractors

Licensing and regulation of private employment agencies, including labor contractors, by State and Federal laws are needed.

Transportation

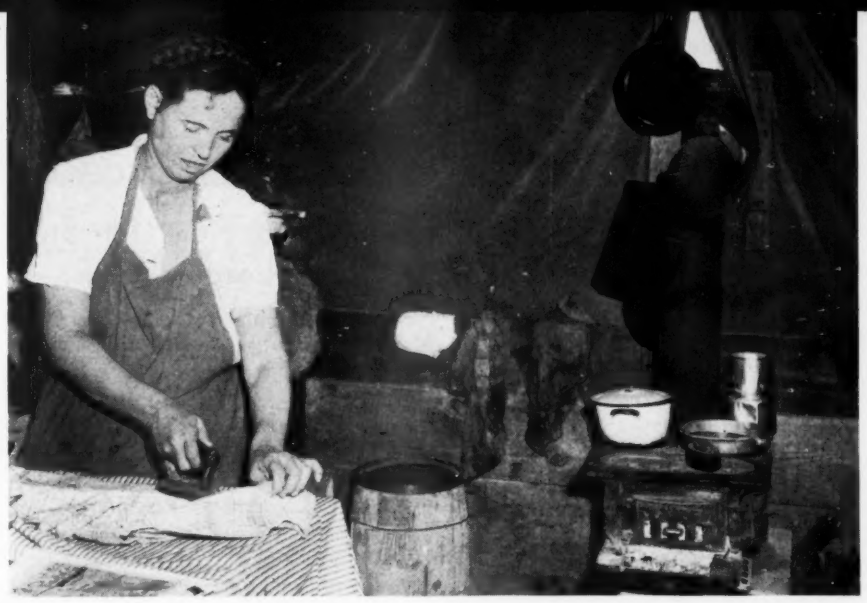
Migrant workers are often transported long distances under dangerous, unhealthful conditions. They are often transported by the labor contractors who act as their representatives in dealing with employers. The council favors extension of the Interstate Commerce Act to give the Interstate Commerce Commission jurisdiction over private transportation of workers from State to State, as well as regulation of intrastate transportation of workers under State laws.

Wages

Migrant labor is for the most part unorganized. It is not now adequately protected by either Federal or State wage laws. Ill-informed, pressed always by immediate need, employed only part time, migrant workers are not able to earn enough to support themselves and their families in decency. The council wants to see the Federal Fair Labor Standards Act extended to agricultural workers, and State laws adopted to provide for prompt and regular payment of migrants' wages in cash, and for collection of unpaid wages.

Workmen's compensation

Migrant workers, except for those in one or two States and Territories, are not now eligible for workmen's compensation. But the accident and death rates in agriculture are as high if not higher than those in other major industries. The council believes that State workmen's compensation laws should be extended to agricultural workers and that minimum premiums should be reduced to employers so that agricultural workers may have the protection of insurance covering small numbers of workers and for short periods of employment.



Home, sweet home, for this mother and her family is nothing but a succession of tents, shacks, and other so-called shelter. Housing is one of the worst problems of migrant laborers.

Social security

A sizable group of workers, needing the benefits of social insurance if they are ever to better their conditions, are now denied that help. The Federal Social Security Act must be extended to all migrant workers, including the benefits of unemployment, old-age, and survivors' insurance, and public assistance; removal by States of residence requirements as a condition of such benefits is also essential.

Unless all groups concerned in the migrant labor situation — employers, the workers themselves, local communities, local, State, and Federal Governments, public and private organizations, and interested individuals—work together, the conditions under which migrant workers and their families work and live will remain shocking and contrary to what we consider the rights of every American citizen.

Reprints available in about 5 weeks

Another move for these children of migratory agricultural laborers. What will their new location have for them in educational opportunity and in health and welfare services?

IN THE NEWS

Act of Congress Authorizes International Cooperation in Work for Children

When President Truman on January 27 signed Public Law 402, often referred to as the Smith-Mundt Act, legislative authority became available for a broad program of cooperation and exchange of information between the United States and other nations of the world. In other words, the United States will be able to carry on, in collaboration with the nations of Europe, the Near and Middle East and the Far East, joint projects similar to those which have been developed with such outstanding success in cooperation with the other American Republics.

Plans already are under way for expansion of the program from hemispheric to global proportions. Exchange of information and experience in the fields of maternal and child health and welfare, at the request of governments other than those of the American countries, now has definite legislative authorization. Expressions of interest in this type of cooperation began to reach the Children's Bureau even before final passage of the act, furnishing additional proof of the fact that the health and welfare of the younger generation is a primary concern of people everywhere.

Following the pattern already well established in this hemisphere, where agencies of the Federal Government are cooperating with their counterparts in other American countries, under a program coordinated through the Interdepartmental Committee on Scientific and Cultural Cooperation of the U. S. Department of State, doctors, nurses, social workers, nutritionists, and specialists in many other fields of work for mothers and children, may be sent to other countries on request. Other nations may send similar specialists to the United States. From this sharing of information, experience, and skills, will come greater understanding among the peoples of the world, enrichment of our respective cultures, raising of professional standards in many fields and, above all, greater benefits to children everywhere.

Elisabeth Shirley Enochs

Recommend Plans for State and Local Action

Every State and Territory, and every large community, should have a representative body planning in behalf of children and youth. This was recommended by the Conference on State Planning for Children and Youth, which met at Washington March 30–April 1, convened by the National Commission on Children and Youth and the Children's Bureau, to plan a 2-year State and local program of preparatory action prior to a 1950 White House Conference on Children.

Two hundred and fifty State officials and leaders, representing all but two of the States and Territories, attended the conference.

Pointing out that each State will need to work out its own pattern for planning groups, the conference recommended that three types of such groups be considered: Those organized by legislative authority, those organized through Governor's appointment without legislative action, and those organized under voluntary sponsorship.

Whatever the type, the conference recommended that the planning body should be composed of representatives of established organizations, including public and private agencies, and individual citizens as well. It should be large enough to permit all groups in the community to be represented on it.

In order that the planning body may fulfill its broad purposes and also its specific objectives, the conference recommended that in general its functions include: (1) Fact finding; (2) assessment of facts; (3) acting as a clearinghouse for information; (4) interpreting over-all needs of children and youth and services to meet these needs; (5) planning for and promoting legislation; (6) participating in national planning groups and programs for children and youth, such as the White House Conference of 1950; and (7) coordinating services and programs for the well-being of children and youth.

Further information concerning the Conference on State Planning for Children and Youth will be given in a future issue of *The Child*.

Communities Observe National Boys and Girls Week

"Youth—Key to the Future" is the theme of the twenty-eighth annual National Boys and Girls Week, which will be observed April 24 to May 1, 1948. Boys and Girls Week calls attention to the organizations and programs serving the needs of youth and seeks to arouse the interest of the entire community in supporting measures to strengthen and ensure the wholesome, purposeful development of all boys and girls.

For Training Health Personnel

In an effort to meet the great need for doctors, nurses, medical social workers, nutritionists, and dentists, to take part in carrying out the maternal and child-health and crippled children's program under the Social Security Act, funds under the act are now budgeted to the amount of more than $1,500,000 for training these types of personnel.

Approximately half of this amount is being expended by State agencies for stipends, tuitions, and travel of trainees, and the other half for development of postgraduate courses at educational institutions.

Some of these postgraduate courses, the plans for which have been developed jointly by the educational institutions, State agencies, and the Children's Bureau, are as follows:

In the field of medical social work, courses have been, or are being, established at Tulane University, University of Chicago, Boston College, Boston University, and Simmons College.

Nursing courses have been, or are being, established at the University of Colorado; Charity Hospital, New Orleans; Indiana University; Wayne University; the University of Cincinnati; Meharry Medical College; Vanderbilt University; the Johns Hopkins Hospital; Columbia University; and Boston University.

In the field of public health, maternal and child-health courses have been strengthened at the Harvard School of Public Health, the Johns Hopkins School of Hygiene and Public Health, and the University of California School of Public Health.

Medical education, undergraduate and postgraduate, has been strengthened at the University of Colorado, the

University of Nebraska, Louisiana State University, Meharry Medical College, the University of Arkansas, the University of Tennessee, and the Johns Hopkins University.

Postgraduate courses in children's dentistry have been established at Meharry Medical College and the University of Tennessee.

At Western Reserve University provision has been made for supervision of field training for postgraduate nutrition students.

Academy of Pediatrics Issues New Monthly

Beginning with January 1948, the American Academy of Pediatrics is publishing a monthly called *Pediatrics*, owned and controlled by the Academy.

According to its announcement, *Pediatrics* publishes papers on scientific and clinical investigation in the field of pediatrics. It also includes papers on public health and preventive medicine, genetics, nutrition, psychology, education, social legislation, nursing, and sociology, when the subject matter is related to child health and welfare. *Pediatrics* is the medium of expression of the Academy to the medical profession and to the public. Contributions dealing with special spheres of interest to pediatricians are published in feature sections.

To Study Effects of War on Children

A research grant of $20,000 has been awarded, upon the recommendation of the National Advisory Mental Health Council, to the International Committee on Mental Hygiene to study the effects of war on children. This study will be made under the direction of Dr. David Levy and will be presented at the International Congress on Mental Health to be held in London in August 1948.

• FOR YOUR BOOKSHELF

CITIZENS LOOK AT EDUCATION; a progress report by the Citizens Federal Committee on Education, 1947–48. Prepared by the Subcommittee on the Teacher in America. Federal Security Agency, U. S. Office of Education. Washington, 1947.

The present school year marks the beginning of a turn for the better in education in the United States, says this report. There is abundant evidence that the ominous deterioration of our educational system has been arrested. The public has become aroused to the danger threatening our schools and in many places has acted decisively to improve conditions.

In order that the gains of the past year may be placed in proper perspective, the Subcommittee on the Teacher in America offers this progress report which stresses what remains to be done, and recommends that the individual citizen do four things for improvement of the schools: (1) Check up on educational conditions in your own community; (2) Work with organizations seeking to improve educational conditions; (3) Get to know your children's teachers and show them they have your understanding, friendliness, and support; (4) Encourage able young people to consider teaching as a career.

MONEY MANAGEMENT: CHILDREN'S SPENDING, by Martha Bennett King. Household Finance Corporation, 919 North Michigan Avenue, Chicago 11, Ill., 1946. 40 pp. 5 cents.

Fourteen persons eminent in various pertinent fields were consulted in the preparation of this booklet, as well as many references on the subject. Despite the fact that one of the few studies on children's use of money, that of Dr. Esther Prevey, does not appear to have been used, the good sense and practical experience of those whose ideas are synthesized in the pamphlet, make it a most desirable contribution to parent education.

Every question and objection that parents ordinarily bring up about their children's handling of money is taken up reasonably and practically, and the reader is persuaded right on through to the end by the lively format and illustrations. The author's humorous touches should do a lot toward helping parents to accept some ideas they might otherwise reject or take too seriously.

Marion L. Faegre

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A limited quantity of each of the following items, reprinted by the Children's Bureau from sources outside the Bureau, is available for distribution. Single copies may be had without charge.

The California Hearing Conservation Program. By Jessie M. Bierman, M.D. and Donald R. Caziarc. *American Journal of Public Health*, April 1947.

Formula Room Experiment in Terminal Sterilization. By Robert H. Lowe, M. D. *The Modern Hospital*, August 1947.

The Newborn: His Family and the Modern Hospital. By James Clark Moloney, M. D., John C. Montgomery, M. D., and Genevieve Trainham, R. N. *The Modern Hospital*, December 1946.

Psychiatric Consultation in Case Work Agencies. By Jules V. Coleman, M. D. *American Journal of Orthopsychiatry*, July 1947.

The Public Health Nurse and the Emotions of Pregnancy. By Kent A. Zimmerman, M. D. *Public Health Nursing*, February 1947.

Responsibility for and Use of Interim and Emergency Placement. By Leon H. Richman. *Social Service Review*, September 1946.

What Preparation Should an Institution Give a Child for Better Living in a Community? By Frederick G. Behrends. *Tennessee Public Welfare Record*, June 1947.

• CALENDAR

Apr. 24–May 1—National Boys and Girls Week. Twenty-eighth annual observance. Further information from the National Boys and Girls Week Committee, 35 East Wacker Drive, Chicago 1, Ill.

Apr. 25–28—International Council for Exceptional Children. Twenty-fourth annual convention. Des Moines, Iowa.

May 1–2—Society for Research in Psychosomatic Problems. Atlantic City, N. J.

May 1–4—National Health Assembly, Washington, D. C.

May 5–8—National Conference on Family Life. Washington, D. C.

May 7–8—American Council on Education. Thirty-first annual meeting. Chicago, Ill.

From May 10—Population Commission. Third session. Lake Success, N. Y.

May 16–19—Third National Citizenship Conference. Sponsored by the National Education Association and the U. S. Department of Justice. Washington, D. C.

May 19–22—American Hearing Society. National conference and annual meeting. Pittsburgh, Pa.

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FOR HUNGRY CHILDREN

Millions of children overseas are hungry, cold, and sick because there is not enough money to feed them, clothe them, and relieve their suffering.

For the sake of these victims of war, the American Overseas Aid-United Nations Appeal for Children is asking each of us in this most fortunate country to give as much money as we can. We are asked to give a total of at least $60,000,000.

This sum, plus what the United Nations Appeal for Children is collecting in a number of other countries, will bring food, warm clothes, and some medical care to large numbers of children who are now hungry and shivering, and—many of them—ill.

Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, has seen many of these children. Dr. Eliot was on loan to the International Children's Emergency Fund for 4 months last year as chief medical consultant, and spent 11 weeks visiting ravaged European lands.

After her return Dr. Eliot said: "Conditions have grown even worse for children this winter, because of the extensive drought during the summer and fall, and because all UNRRA supplies are exhausted. Governments are struggling to feed, clothe, and give medical care to children, but some 30,000,000 are in urgent need of food, especially milk, fats, and proteins. The situation in many places is desperate."

Other observers have found the same conditions. I myself had first-hand contact with some of these conditions when I went to Europe last fall to attend a meeting of the Executive Board of the United Nations International Children's Emergency Fund.

Only a fraction of the children who need food, clothing, and medical care are now receiving it, although the UNICEF and many voluntary relief agencies are doing all they can with the money they have.

The UNICEF has already made provision for nearly 4,000,000 children and nursing mothers in 12 European countries to receive supplementary foods, usually as part of a daily meal, including special protective foods (milk, fats, and cod-liver oil, and some meat); UNICEF is also planning to aid Chinese children. Its support comes largely from 16 governments and from the residual assets of UNRRA, and this will be supplemented by funds from the worldwide appeal now under way. The various foreign-relief agencies supported by voluntary funds are also aiding large numbers of children overseas.

The President of the United States has made his appeal to all of us. "In contributing to American Overseas Aid and the United Nations Appeal for Children," President Truman has said in a letter to Lee Marshall, chairman of the Board of Directors of AOA–UNAC, "thoughtful Americans will be giving an effective demonstration of their traditional humanitarian concern for the welfare of people in distress and providing an example of our democracy in action.

"The United States Government," he points out, "is doing what it can to promote the economic rehabilitation of a number of countries which have indicated a willingness to help themselves to the best of their ability. Through American Overseas Aid, the American people have an opportunity to back this policy with voluntary support for private agencies which, over a period of years, have proven their effectiveness in the field."

In concluding, President Truman writes: "I am convinced the American people are determined that the world's children shall have at least a chance to survive and I know of no better way of transforming that determination into action than by supporting American Overseas Aid and the United Nations Appeal for Children."

Let us give the world's children at least a chance to survive.

Katharine F. Lenroot

Chief, U. S. Children's Bureau

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